Should the current individual and small-group markets be merged?

Overview of Options

1. Merge the individual and small-group markets effective January 1, 2014.

2. Take no action at this time (i.e., do not merge the markets, and do not plan a study)

3. Defer a decision about merging the markets until several years of experience under health reform is available. Plan a study of that experience.

Background Facts

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For the individual (non-group) market:

- About 165,000 Marylanders had individual coverage in 2010. (MIA)
- When fully phased-in, the individual Exchange is expected to enroll about 405,000 Marylanders. (Urban Institute estimate)
  - About 245,000 of these will be below the 400%-of-poverty cut-off for individual premium tax credits.
  - Whether those above 400% of poverty will join the Exchange or buy in the outside market is extremely difficult to predict. (But, regardless, they will all be part of the single individual-market "risk pool.")
  - Some current enrollees will choose to stay in their current ("grandfathered") plans.

For the small-employer market:

- About 365,000 Marylanders had coverage through insured small-group products in 2010. (MHCC)
  - Some others may have been covered through self-insured small employers.
- Whether health reform will cause this enrollment figure to increase or decrease is hard to predict:
  - Employers with fewer than 50 full-time-equivalent employees face no federal penalty if they don't provide health insurance. Some small businesses that currently offer coverage may decide to drop it—especially if they have many low-income workers who could qualify for tax credits in the individual Exchange.
  - Some employers that do not now offer coverage may decide to begin doing so to enable their workers to comply with the "individual mandate"—especially if they have a number of higher income workers who would not qualify for tax credits but can benefit from the tax breaks available for employer-sponsored coverage. The federal small-business tax credit (which increases in 2014, but is then limited to 2 years) may attract a few lower wage small employers to newly offer coverage.
  - Some workers currently decline coverage their employer offers them. If they are not covered elsewhere, they may enroll in their employer's plan to comply with the "individual mandate." (They can not qualify for tax credits in the individual Exchange unless their employer's coverage offer is "unaffordable.")

So the individual market may equal or exceed the small-group market in enrollment.

What does "merging the markets" mean?

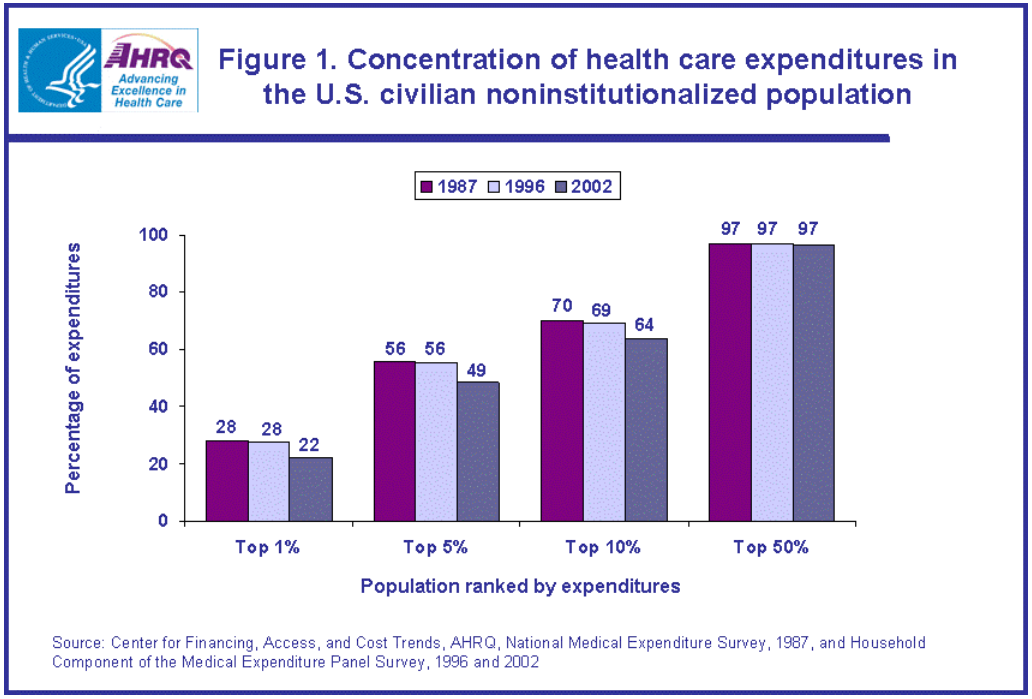
It means …	But …
• The same carriers ("issuers") would serve both markets. • Carriers would have to make the same products (plans) at the same age-rated premiums available to any individual or small-employer group.	• There would still be distinctions between individual and small-group coverage. » Coverage sold to individuals would still be individual coverage, and coverage issued through an employer group (or through the SHOP) would still be employer coverage. » This distinction remains significant for tax purposes and for plan administration.

The SHOP and the individual Exchange would each retain some unique functions that the other does not need to perform:

The individual Exchange …	The SHOP Exchange …
• … must determine eligibility for individual tax credits and display after-tax-credit prices for individual purchasers.	• … must determine that the employer is qualified and meets any contribution and participation requirements the SHOP chooses to establish..
• … must give each individual the option to pay the health plan directly. » The Exchange may opt not to collect any private premiums at all.	• … must bill and collect from the employer for the total premium payable with respect to all enrolled workers, and transmit the appropriate premium to each QHP the employer's workers are enrolled in.
• … cannot administer the advance federal tax-credit portion of the premium (which is paid directly to the plan by the U.S. Treasury.)	• If the employer has elected to give workers a choice among available QHPs, the SHOP bill to the employer should list both the employer's and the worker's contribution for each worker.

Why Is "Adverse Selection" a Potential Problem?

- In any given year, a large portion of health care expenditures are incurred by a relatively small percentage of the population. (See chart.*)
  - Basically, half the population incurs essentially no medical care costs (i.e., only 3% of total health care expenditures), while the other half incurs 97% of total expenditures.
  - And only about 5% of the population accounts for essentially half of total health expenditures.
- So, if one health plan enrolls relatively more of that unhealthy 5% than other plans, its average costs will be considerably higher than its competitors.
- Risk adjustment will compensate for some but not all of the resulting cost differences.



* Although this chart is relatively old, newer data from the same source confirm that the percentages in 2007-2008 remained the same (±1%) as in 2002.

Merge the Markets on January 1, 2014

The individual and small-group markets would be merged effective January 1, 2014.

➤ Key Consideration: People who currently cannot obtain individual insurance due to medical underwriting will be among the first entrants to the new, "guaranteed-issue" individual market. Therefore, average costs in the individual market will initially be high. Whether the transitional reinsurance and risk-corridor programs will be sufficient to compensate for this effect is uncertain.

Advantages	Disadvantages
• Would likely reduce immediate post-reform premiums for individuals by providing a base of relatively well-known risk (small employer groups) to offset the uncertain (but expected to be higher) risk of new individual entrants. » This would primarily benefit higher-income individuals not eligible for premium tax credits. (Tax credits protect those eligible from higher market-wide prices.)	• Would almost certainly raise early-reform-year premiums for small employer groups. (Only a formal actuarial study could estimate the likely size of the premium increase.) • Higher premiums, or fear of them, could drive some small employers out of the insured market (either to self-insured coverage or to drop coverage entirely). » This would increase health insurance costs for any workers involved, e.g., due to loss of tax benefits associated with employer coverage.
• Could improve number / range of plans available through SHOP Exchange. » Worker-choice requirements could discourage carrier participation in the SHOP, but if markets are joined, carriers would be more likely to offer plans in the SHOP in order to get access to tax-credit recipients in individual Exchange.	• Adds an unnecessary, potentially de-stabilizing factor in the early days of reform implementation. • Carriers aren't set up to handle the administrative costs of realigning businesses, departments, etc.
• Could improve continuity of coverage / provider relationships for people moving between individual and small-employer coverage.	• Could reduce continuity of existing employer group plan arrangements.

Take No Action

The individual and small-group markets would not be merged, and no study would be planned. (I.e., no firm date for re-visiting this decision would be established.)

Advantages	Disadvantages
• Premiums for small employer groups will be more predictable and most likely lower than they would be in a merged market.	• Premium costs for individuals not eligible for tax credits will likely be higher than they would be in a merged market.
• Avoids an unnecessary, potentially de-stabilizing action for the small-group market in the early days of reform implementation,	• Having different plans and markets could reduce continuity of coverage and provider relationships for people moving between individual and small-employer coverage.
• Other?	• Failure to plan a formal actuarial study could mean that key data for such a study is not captured during the early years of reform operation.

Defer a Decision

Under this option, the individual and small-group markets would not be merged on January 1, 2014, but an actuarial study would be conducted based on experience in the two separate markets during at least 2015 and 2016. (Experience during the start-up year of 2014 would not be considered.) Based on that study, the issue of whether or not to merge the two markets could be revisited with better information.

- The study would focus on, but not necessarily be limited to, the probably effects on premiums for individuals and for small employer groups of merging the two markets.

Advantages	Disadvantages
• For the first several years, premiums for small employer groups will be more predictable and most likely lower than they would be in a merged market.	• For the first several years, premium costs for individuals not eligible for tax credits will likely be higher than they would be in a merged market.
• Avoids an unnecessary, potentially de-stabilizing action (particularly for the small-group market) in the early days of reform implementation,	• Having different plans and markets could reduce continuity of coverage and provider relationships for people moving between individual and small-employer coverage.
• Planning a formal actuarial study could help assure that key data needed for such a study is captured during the early years of reform operation.	• Continuing uncertainty regarding a potential market merger.
• Other?	• Other?

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Should the small-group market be defined to include employers with 51-100 employees effective 1-1-2014?

Overview of Options

1. Yes. Define the small-group market to include employers with 51-100 employees effective January 1, 2014.

2. No. (Under federal law, the small-group market must include such employers effective January 1, 2016.)

Background Facts: Relative Market Sizes

For the current small-employer market (employers with up to 50 employees)

- Just under 45,000 small employer groups had coverage through insured small-group products in 2010. (MHCC)
  - They covered about 365,000 Marylanders (workers and dependents)
  - But only a minority of businesses with up to 50 employees offer coverage.
    - » MHCC estimates 35% of small businesses offer coverage.
      MEPS employer survey for Maryland estimates 47%.
  - Even when the employer offers coverage, not all workers are eligible, and some of those who are eligible decline to enroll. (This reality more than offsets the fact that the percentage of employers offering coverage increases with the size of their workforce.)
    - » Only about 37% of Maryland small-business workers are enrolled in coverage offered by their own employer. (MEPS employer survey for Maryland, 2010)
- **Including businesses with 51-100 employees would increase enrollment in coverage provided by "small employers" by 20%-25%. (IHPS estimate based on the MEPS employer survey for Maryland, 2010.)**
  - Such businesses are much more likely to offer coverage than smaller businesses (89% v. 47% per the MEPS employer survey for Maryland), but even here, only 44% of workers are actually enrolled in coverage offered through their own employer.

Regulatory Structure and Implications

Current Small-Group Market (up to 50 employees)	Larger Group Market (51 or more employees)
• Guaranteed issue (i.e., coverage cannot be denied)	• Underwritten (i.e., carrier can decline to cover the entire employer group)
• Modified community rating required, i.e., premiums cannot be based on actual or expected experience of a particular employer group.* » Premiums can vary by ±50% based on age and geographic location. (Federal rules effective 2014 allow ±50% for age, also allow geography and tobacco use.)	• Experience rating allowed (i.e., premiums can be set to reflect actual or expected claims experience of the particular employer group).
• Therefore, all Maryland small groups with the same average age in the same geographic area, buying the same insured product from the same carrier, pay the same premium.	• Therefore, low-risk groups (those with healthier workers + dependents) now pay substantially less than higher risk groups (those with sicker workers or dependents).

* Effective July 1, 2010, Maryland law now allows carriers to adjust rates for health status for new groups entering the small-group market during each group's first three years of participation. (The allowable rate variation declines from ±10% in year 1 to ±5% in year 2 and ±2% in year 3.)

What Is "Self-Insurance"?

"Buying insurance" means that the employer pays a set premium for a set period, and the insurer agrees to pay all covered medical expenses incurred by all covered workers during that period.

- If total expenses exceed the total premium paid, the insurer, not the employer, is at risk. Conversely, if total expenses are less than the total premium paid, the insurer, not the employer, pockets the difference.
- What happens to an employer's premiums for the following year, however, depends on whether the employer group is "experience-rated" (like a large employer) or "community rated" (like a small employer).

But employers do not have to "buy insurance" to provide health coverage to their workers. Employers can alternatively decide what medical expenses they are willing to cover, and pay the expenses for those services for their enrolled workers directly. This is called "self-insurance." (Usually a self-insured employer hires an insurer or a third-party administrator to pay its claims, but that administrator is not at risk for the claims.)

Obviously, only the largest companies would be willing to take on the entire risk of health coverage for their workers. For example, for a small employer, the cost of one premature baby could be catastrophic.

But insurers often offer employers "reinsurance" or "stop-loss insurance" that reduces the employer's risk and makes "self-insurance" feasible even for relatively small employers.

- There are different forms of reinsurance. Some pay claims that exceed a specified dollar amount for any particular covered employee or dependent. Others cap the employer's liability, in total, at some percentage (greater than 100%) of expected total expenditures for the employer's group.

Why Is Self-Insurance Attractive to Some Employers?

If an employer's premiums for insured coverage are experience-rated (as they can be for Maryland employers with 51-100 employees at present), self-insurance can be attractive to avoid "risk premiums" and other expenses charged by carriers for insured plans, to avoid state benefit mandates, and to simplify administration of multi-state employer plans.

- Under ERISA, states cannot prescribe what medical expenses an employer does or does not cover. States can only prescribe what insurers must cover. So, an employer that buys insurance is subject to the state's benefit mandates indirectly (as it were); but a self-insured employer is not. (Self-insured and larger employer plans are also not required to cover federal Essential Health Benefits under the ACA.)

If an employer's premiums for insured coverage are community-rated (as they are now for Maryland employers with 50 or fewer employees), then employers with relatively healthy workforces have an additional motivation:

- In a (modified) community-rated pool, regardless of its workforce's health risk profile, every employer group pays the same defined premium rate (varying only by age, geographic location, and whether or not dependents are covered).

- So, if a particular employer's workers (and their covered dependents) are relatively healthy, that employer will pay more (perhaps considerably more) than the actual cost of their workers' medical expenses to buy insurance.

- For this kind of employer, self-insurance (with appropriate stop-loss protection) becomes very attractive.

Even in the current Maryland market (where 51-100-employee groups can be experience rated), rapid growth in self-insured arrangements (with stop-loss reinsurance) is reported.

- **Advisory committee members report that virtually all new quotes for 51-100-employee groups are for such self-insured arrangements.**

State attempts to limit self-insurance by small employers—generally by seeking to regulate stop-loss insurance as health insurance when its "attachment points" are below certain levels—have for the most part been rebuffed in the courts.

Why Is Self-Insurance a Problem for the Small-Group Market?

Under health reform, insurers must treat all their (insured) small-group business (both inside and outside the SHOP Exchange) as one "pool."

Within that pool, premium rates are to vary only by the age of the covered person (with a maximum variation of 3:1 from highest to lowest—the equivalent of ±50%) and by geographic location, tobacco use, and whether or not dependents are covered.

Risk adjustment, which also applies across the entire insured small-group market, as well as risk corridors, help to pool risks are pooled across the entire insured small-employer market.

But, if the lowest cost (small) employer groups choose self-insurance, then they are not part of the insured small-group market.

With the lowest cost groups out of the insured pool, the average premium for the groups remaining in the pool will be higher.

Define the small-group market to include employers with 51-100 employees effective January 1, 2014.

Advantages	Disadvantages
• Provides more affordable access to higher risk 51-100-employee employer groups.	• Likely to increase average premiums for the insured small-group market due to adverse selection.
• Could increase both overall size of small-group market and average size of groups in that market, and bring down average administrative costs for the entire market.	• As a result, could increase movement to self-insurance among employers with 50 or fewer employees.
• Could provide workers in 51-100-employee firms with access to worker choice of plans (where available through SHOP Exchange).	• Adds an unnecessary, potentially confusing and potentially de-stabilizing factor in the early days of reform implementation.
• Could expand population enjoying continuity of coverage and provider relationships when switching jobs.	• Reduces flexibility in plan design for employers with 51-100 employees.
• Other?	• Could shift market focus, reduce help available to smaller groups.

Defer expanding the small-group market until the federally required date of January 1, 2016

Advantages	Disadvantages
• Avoids potentially significant premium increases for current insured small-group market (which could increase movement to self-insurance among employers with 50 or fewer employees).	• Does not improve access / costs for higher risk 51-100-employee groups.
• Avoids an unnecessary, potentially de-stabilizing action in the early days of reform implementation,	• Limits the population enjoying continuity of coverage and provider relationships when switching jobs.
• Other?	• Other?

Key Consideration for Both Issues

- The primary reason to consider either merging the individual and small-group markets or expanding the small-group market up to 100 employees is the need for "critical mass"—a risk pool that is large enough to be stable.
- It appears that both the individual market and the small-group market as currently defined (up to 50 employees) are sufficiently large on their own and do not need to be merged to attain critical mass. (Note that the Maryland circumstance is very different from that in Massachusetts, where the individual market was much smaller than the small-employer market, and much more expensive due to community rating with no individual mandate.)
- Another potential reason to expand the small-group market is to guarantee affordable access for firms with 51-100 employees. This does not seem to have been a problem in the current Maryland market. (However, the reported rapid shift to self-insured arrangements for this size range may mean that higher risk employer groups in this size range will be faced with unaffordable costs and/or risks for coverage.)